similar to that which exists in Manchester, as the Corporation refused to adopt the Manchester scheme, and at present the guardians pay only for persons proved to belong to the poorest classes.

BIRMINGHAM.

Resignation of Professor Malins.

Dr. Edward Malins, who has held the chair of midwifery in the University of Birmingham, and previously in Mason College since the year 1894, has tended his resignation. In his letter of resignation Professor Malins expresses his grateful appreciation of the consideration he has constantly received both from the authorities and his colleagues in the conduct of the department he has had in charge. Acknowledging the privileges of citizenship and recognizing its duties and obligations, he at the same time sent a cheque for £1,000 as a contribution towards the general expenses of the university with, to quote his own words, "a profound sense of the many important advantages it offers to the advancement of knowledge and the great capabilities it opens to the future in the highest interests of intellectual and material progress in our midst."

Correspondence.

RESEARCH DEFENCE SOCIETY.

Special Appeal.

Sir,—We are of opinion that experiments on animals in this country should be restricted by law, that the present Act should be efficiently administered, and that the utmost care should be taken to ensure the minimum of pain in these experiments.

Some of the antivivisection societies have lately adopted methods which are grossly offensive to the public interest. They have opened no less than sixty shops in London and elsewhere. Most of these shops have lasted only a few weeks, but they have had time to spread falsehood, prejudice, hatred, and suspicion against scientific research. They have also done harm to small children. It is no light offence to exhibit in public not only brutal cartoons and caricatures, but stuffed animals, tied down for operation, while the truth is carefully concealed that no operation is allowed on any animal in this country except under an anaesthetic.

In this connexion we would remind the public of the unanimous statement of the Royal Commission:

> To represent that animals in this country are wantonly tortured would, in our opinion, be absolutely false.

The excuse is offered, for these shops, that the appliances displayed in the window are actually supplied by the makers. But if the appliances used in our hospitals were displayed in a shop window, with models of human beings tied down for operation, it would be no excuse for such a travesty, to say that the appliance had acually been supplied by the makers.

Some of these societies, having wealth at their disposal, are able to rent shops in the most crowded thoroughfares, or to attract by the very lavish and rather unscrupulous use of money, a large audience. It seems that an effort is being made to work on the mere liking for horrors, real or sham: that no exhibit is too sensational, if it can serve to draw attention and to excite passion.

When we think of the vast multitudes of lives, human and animal, saved from pain, disease, and death by discoveries made through experiments on animals, we cannot believe that the present methods of antivivisection societies are acceptable to sensible and honest people.

The only way to fight these methods is to be constantly publishing the facts of the case put before the Royal Commission and embodied in its final report. The Research Defence Society, in the past twelve months, has given more than a hundred addresses and lantern lectures in all parts of the kingdom, and has distributed more than half a million pamphlets and leaflets. But there is much more work waiting to be done if we had the money for it. We therefore appeal for special donations, to be controlled by the committee of the society, and to be used solely for such purposes of education as public lectures and distribution of literature. All cheques should be crossed "Messrs. Coutts and Co.," and made payable to the Honorary Treasurer, Research Defence Society, 21, Ladbroke Square, London, W. We hope and believe that this appeal, in the interest of the public, will be very generously answered. On behalf of the Society, we are, etc.,

David Gill,
President.
Sydney Holland,
Chairman of Committee.
Robert Cecil.
Luke Fildes.
William Ramsay.
Mary Scharlieb.
F. M. Sandwith,
Honorary Treasurer.

London, W., July 10th.

APPENDICITIS—AND QUICKNESS.

Sir,—If readers of the Journal will turn to Sir George Beatson's first letter (June 3rd) they will see that it is the question of early operation in appendicitis he is discussing, and not merely the mortality, though, of course, that is the most important consideration. Hence, when he wrote that he had no fault to find with operation in the first twelve hours, the obvious meaning was that he had not. He now tells us why he has. He tells us one reason is because it creates a belief that operation is necessary at that time. This is the belief that many of us would wish created in the minds of all surgeons—and in the minds of general practitioners also. It is quite a mistake to represent the views of those surgeons who advise operation in all acute cases in the way Sir George Beatson does. We do not claim that all cases which recover after early operation "are snatched from the jaws of death." We know quite well that a certain number might recover without operation (but would very likely have a relapse and require operation eventually), but, as Sir George Beatson cannot tell us how to determine the "merits" of the case, we believe that there is too great a risk in leaving a diseased appendix, the exact condition of which Sir George Beatson admits he cannot determine by any clinical signs, for we know how often the appendix is found just ready to infect the general peritoneal cavity, without any protective walling-in, and that even when walled-in, and surrounded by pus, there are many dangers for the patient to face until the abscess is evacuated. I quite agree with Sir George Beatson that it does not matter whether the appendix is perforated or gangrenous if it is walled-in. But who can tell that it is safely walled-in? Even when it is, pus formed around it will certainly need evacuation.

I foretold in my last letter that Sir George Beatson in his next would tell us we had better not operate on any case until the interval stage. He now goes almost as far as this, for he says "that when the acute attack has existed for more than twenty-four hours, unless there are definite symptoms of general suppurative peritonitis, operation is best postponed, as such cases under medical management do well, and can be safely brought to the 'interval stage,' when the operation mortality is *nil*." Of course, the operation mortality is *nil* at this stage, but the question is, Can they all be brought safely to it without operation? Most surgeons would agree that all cannot. Sir George Beatson has now ceased to advise us to judge cases on their "merits." We are now told we are to abstain from operation unless signs of general peritonitis are present. Perhaps such signs constituted in his mind the "merits" of the case; at any rate, he does not seem able to give us any other reliable indication when to operate. It is to be noted that Sir George Beatson writes of a period of twenty-four hours after the onset as the time when we are no longer to undertake operation. He has often told us it should be twelve hours. Has he any definite period in his mind? If so, I would ask, as Mr. Paterson has already done, Why?

With reference to the 59 cases of appendix abscess, quoted by me from Mr. Makins's article, Sir George Beatson says: "I have furnished him with valuable confirmatory evidence in favour of the very point he is contending for—namely, that interference with localized appendix abscess in its acute stage is most disastrous, and sets up a train of complications that are at the root of

our heavy mortality statistics in acute appendicitis. . . . " How Sir George Beatson could get this evidence out of Mr. Makins's article I fail to see. I should have thought the evidence was all the other way. For, evidently, such complications as intestinal obstruction, subdiaphragmatic abscess, etc., were not due to the operation, but occurred because it was not performed earlier, and Mr. Makins points out that "the 'early operation,' if performed as a routine procedure, would lead to the disappearance of practically the whole of the complications which at the present time account for the fatalities which occur; further, that the early operation may be fairly placed in the same category as regards mortality with that performed during a quiescent interval."

But with regard to mortality in operation for appendix abscess, I may say that during the last three and a half years I have operated on 32 cases of appendix abscess with only one death. This was from perforation of the stump of the appendix, during the apparently satisfactory progress of the case. The appendix was gangrenous. This is the only case in which I have ever had leakage of an appendix stump. Up to three and a half years ago I had several deaths in children after operation in acute localized appendicitis, with symptoms like those of late chloroform poisoning. At that time I adopted the suggestion of Mr. Harold Stiles that chloroform should not be given to children in these cases, and have since then always had them anaesthetized with ether by the open method, and have had no death with such symptoms since.

It is most satisfactory that in Sir George Beatson's series of 69 cases of appendix abscess none of the serious complications arose which were present in the 59 cases referred to by Mr. Makins, but I feel sure it was not "dietetic or medicinal measures," as Sir George Beatson suggests, which led to the fortunate result. To put it in a few simple words, it seems to have been just good luck. Does Sir George Beatson wish us to believe that such measures will prevent kinking of coils adherent in the abscess wall, or subdiaphragmatic abscess, or empyema—complications which together make 11 out of the 22, or that they will prevent the occurrence of faecal fistula which existed in six more?—I am, etc.,

Bristol, July 13th. CHARLES A. MORTON.

SIR,—Sir George Beatson, in his reply to my letter, states that "the majority of cases of acute appendicitis can be brought to the interval stage by medicinal treatment without undue risk." That this is true of some cases is indisputable. There are, undoubtedly, two classes of cases—those in which recovery will ensue without operation and those in which it will not. That those in which recovery will not ensue are "small in number," and "easily recognizable," is an opinion which I venture to think is not held by the majority of those with much experience of acute appendicitis. It is because of the difficulty—nay, the impossibility in many instances—of distinguishing between these two classes of cases, that early operation is safer than procrastination.

Sir George assures us of the safety of his teaching, but does not tell us how the cases which may be safely left are "easily recognizable." The question of treatment turns on the possibility of this easy recognition. I asked Sir George a definite question, "Can he, or can he not, judge accurately the condition of the appendix in any given case, and foretell the future course of the disease—whether resolution will occur, or whether gangrene with diffuse general peritonitis will ensue?" To this plain question he has not yet given a plain answer; in his second letter he ignored it, in his third he evaded it by saying that "so long as a case of acute appendicitis is a localized one, there is no need to fix definitely the condition of the appendix." This, I venture to maintain, is begging the whole question. By his statement Sir George claims either that all cases of acute appendicitis are localized, which is not the case, or he claims to be able to say in which cases protective adhesions are present, and in which not. Does Sir George seriously claim such diagnostic skill?

"The advocates of immediate operation," says Sir George, "have no right to claim that all such cases when operated on have been snatched from the jaws of death." Surely no experienced surgeon would make any such preposterous assertion. Undoubtedly some of the patients submitted to early operation would have recovered had no operation been performed; but there remain a certain number in which at operation the appendix is found to be perforated or gangrenous, surrounded perhaps by some free-lying pus, and without any protective lymph formation. Is there any reasonable doubt that in such cases, were no operation performed, the infection would spread, and that a diffuse peritonitis would ensue? Evidently Sir George considers that such cases exist only in the imagination of the surgeon. I have had 14 such cases in my last 50.

Sir George Beatson ignores entirely the risk of infection from the appendix causing pleurisy, pneumonia, hepatic abscess, subphrenic abscess, or pyaemia. But if operation be postponed the risk of these complications supervening is no mere "conjured up contingency." In the days when I practised the expectant treatment I had under my care in one year 4 patients who died from one or other of these causes while waiting for an interval operation.

In the lecture to which he refers Sir George gives figures comparing his mortality-rate with that obtaining in the wards other than his own of the Western Infirmary. In view of these figures it would be interesting to know why Sir George's colleagues are not so impressed with his results as to follow his teaching.—I am, etc.,

London, W., July 13th. HERBERT J. PATERSON.

SIR,—It is not my intention to enter into the controversy on this matter, but as an advocate of the early operation I think the statistics which I am able to present may be of some interest.

My practice is to operate on practically every case of appendicitis that comes under my care. For a time cases of general septic peritonitis with distension were not operated upon, but I now nearly always make a small incision or incisions for drainage only, the removal of the appendix being left to a later date. In cases that are in an extremely toxic state when first seen I may deem it wise to wait for twenty-four hours, until the bowels have been got to move and until a greater or lesser amount of saline has been absorbed, and in cases of localized abscess I may defer the operation for from twelve to twenty-four hours as a matter of convenience. In all other cases the operation is carried out as soon as possible.

I attach great importance to the use of ether administered by the open method, to saline given by intermittent rectal injection or by subcutaneous infusion, and to the early evacuation of the bowels.

In almost every case the appendix is removed as an essential part of the operation.

As junior assistant surgeon I am not in a position to hand patients on, and the series represents nearly all the cases of appendicitis that have come before me. The following table shows the mortality of all my cases arranged under the different years:

TABLE I.

Year.	Total Cases.	Deaths.	Percentage.
Previous to 1907	61	8	12.5
1907	68	8	11.76
1908	89	7	7.86
1909	102	3	2.94
1910	107	2	1.86
1911	131	5	3.81
To end of June, 1912 ...	57	0	—
Total	618	33	5.33

I have made a practice of classifying the cases as shown in the next table, which gives the percentage mortality of the different groups.

Group 8 includes cases of intestinal obstruction which ultimately turn out to be caused by an acute appendicitis, and also cases admitted suffering from pylephlebitis.

In Groups 3, 4, 5, and 6, a certain number of secondary operations have been necessary for the evacuation of pelvic abscesses, intestinal obstruction, etc. These are all